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The Physician as Erotomanic Object

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EROTOMANIA, or De Clérambault's syndrome, attracts attention from several perspectives: nosological, psychological, and biological.[1-3] De Clérambault's syndrome borrows its name from the 20th-century French psychiatrist who described "psychose passionelle"—a condition whose central feature is a delusion in which usually a woman believes that an older man of higher social status is in love with her.[1,4] The traditional definition of De Clérambault's syndrome as being a predominantly female condition has not been borne out, however.[5,6] The most recent psychiatric nosology, *Diagnostic and Statistical Manual of Mental Disorders*, third edition, revised (DSM-III-R), has carved out a specific niche for De Clérambault's syndrome as a delusional (paranoid) disorder, erotomanic type.[1,7]

Perhaps the most vexing dilemma raised by this condition is the forensic one. Erotomanic persons cause significant problems for the misinterpreted object of their delusion. A perusal through newspapers and popular magazines finds many articles reporting the escapades or criminal acts of persons whose erotomanic targets are celebrities and politicians. From a forensic perspective, the two most recently prominent persons possibly suffering from erotomanic delusions have been John Hinckley, Jr, who attempted to assassinate then-President Reagan, and Prosenjit Poddar of the landmark legal case of *Tarasoff v. Regents of University of California.*[6]

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Physicians have not been exempt from becoming the object or target of an erotomanic delusion.[8-10] We describe the case of a male patient in whom an erotomanic delusion developed involving his female physician. We then explore the possible psychiatric-legal interventions and unresolved issues in these cases.

Report of a Case

The patient, a 39-year-old, never married, Syrian-American man, was involuntarily admitted to hospital for presenting a danger to his 40-year-old married, Syrian-American family physician, his erotomanic object. The patient first encountered the physician seven years ago after he took his mother to the physician's office for monthly visits after a stroke. The physician later became his personal physician as well. About a year before his psychiatric hospital commitment, the delusion developed that there was a romantic relationship between the physician and the patient as a result of his belief that she was secretly falling in love with him. Over the next several months, he made many telephone calls to the physician, sent her a "love letter" by registered mail, and sent her numerous gifts, including an engagement ring. He spent a great deal of time at the hospital where the physician attended patients and at her hair salon. Because the patient did not comply with the physician's requests to leave her alone, she obtained a restraining order to allow for his arrest if he continued to contact her. The patient remained undeterred and made several attempts over the next several months to contact her to complain about the restraining order. He not only telephoned and paged her answering service but continued to visit her office and the hospital. Four months after the restraining order was filed, on Valentine's Day, the patient sent the physician a Valentine's Day card with a letter accusing her of "gross misconduct," "mismanaging his mother's care," and having "played" on his emotions. He signed the letter, "love always." He was arrested about a month later for violating the restraining order. While in jail, he telephoned the physician and demanded to see her alone "to avoid the inevitable."

This patient had no previous psychiatric contact before the onset of his erotomanic delusion. About a year before the development of his delusion, he began to file lawsuits against various insurance and aerospace companies and believed that he was being monitored by overhead helicopters, that his phone was tapped, and that his apartment had been burglarized with his legal papers being the only items stolen. He had traveled to Washington, DC, to report this harassment to government authorities. He was not given an audience, however, because he had failed to make an appointment. The patient had no history of substance abuse or major medical problems. Although he had completed 2½ years of college, for the past few years he had been able to work only part-time in unskilled jobs and had lived with his elderly mother. He denied having auditory hallucinations.

After his arrest, it was decided that involuntary hospitalization on the basis of posing a "demonstrated" danger to others (California Welfare and Institutions Code §§5300 et seq) for a period of 180 days would be preferable to any legal sanction that could be obtained for a first-offense violation of a restraining order. In addition, treatment of the patient's psychosis could be attempted with hospital admission. The petition for this 180-day involuntary commitment was sustained during a jury trial.

Discussion

This patient suffered from a psychotic disorder manifested by a prominent erotomanic delusion. The DSM-III-R diagnostic possibilities are schizophrenia, paranoid type, and delusional disorder, erotomanic type, with the former being more likely. Notwithstanding any diagnostic ambiguity, the important forensic feature and clinical symptom of his psychotic disorder were his erotomanic delusion and the maladaptive and disturbing behavior arising from it.

Patients in whom an erotomanic attachment to their physicians develops have had actual contact with their erotomanic object. This contrasts to the type of erotomania that develops from afar with celebrities and political figures. The development of an erotomanic delusion involving a person's psychiatrist or other nonmedical psychotherapist can be explained in part as the result of the activation of a transferential relationship that develops within the context of psychological treatment. While nonpsychiatric physicians do not usually develop strong transferential relationships with their patients, they are seen by patients as intelligent, successful, omnipotent, and caring. Because erotomanic patients have generally been unattractive and unsuccessful persons,[1] the selection of a physician as a target can be understood as a psychotic attempt to compensate for the patient's low self-esteem.

Erotomania itself does not generally become a concern for the erotomanic object until the delusional person begins to act on his or her delusion. Before this occurs, any disturbing behavior by the delusional person is generally unknown to the target. The situation becomes difficult when the delusional person perceives rejection from the erotomanic object and decides to vent anger. Even when confronted with the fact that the erotomanic target is not in love with him or her, the delusional person can reason that the erotomanic object behaves paradoxically to disguise true love.[2] The case reported here illustrates the futility of trying to discourage delusionally driven actions, even though the physician was married and had obtained a restraining order against the patient. Less than 5% of erotomanic persons probably do physical harm (Park Elliot Dietz, MD, MPH, PhD, Clinical Professor of Psychiatry, UCLA School of Medicine, oral presentation at a meeting of the Southern California Chapter of the American Academy of Psychiatry and the Law, June 2, 1990). Nonetheless, the inability of the delusional person to cease the maladaptive behavior coupled with the development of a perception of rejection sets the stage for possible physical violence.

If a physician discovers that he or she is the erotomanic target of a patient, an attempt at psychiatric intervention is indicated. If the patient has a psychiatrist (or psychotherapist), the care giver should be contacted. Otherwise, an attempt should be made to refer the patient for psychiatric evaluation. Even if the patient is actively involved in psychiatric treatment, results have not been particularly encouraging.[4] For patients with schizophrenia or a delusional disorder, the only effective treatment has been neuroleptic medication. Even this has not always been successful in diminishing or eliminating erotomanic delusions.[1] If the patient is not involved in psychiatric treatment and continues to present as a behavioral problem, more drastic measures must be implemented. The first is to obtain a restraining order to allow legal action if the erotomanic patient continues to interfere with the physician's professional or personal life. Although there is some risk that a restraining order may exacerbate the erotomanic behavior,[11] this may happen without any intervention by the target. If the delusional patient disregards the restraining order, intermediate-term involuntary commitment can be attempted, as in the case of this patient. Because treatment may not be successful, involuntary commitment may be the only effective method to separate the delusional person from the target.[6]

Obtaining immediate-term involuntary commitment is the best our society can do in dealing with erotomanic behavior. Long-term or indefinite commitment is possible only if a person continues to pose a statutorily defined level of danger. Because many persons in such an adversarial setting could hide their erotomanic beliefs[11] and act in accordance with hospital rules, long-term commitment is not likely to occur. The hope is that the delusional person will be sufficiently discouraged by immediate-term involuntary commitment to discontinue any further involvement with the erotomanic target. Unfortunately, our present system cannot always prevent a tragedy from occurring. Wholesale preventive detention of erotomanic persons is not legally or ethically justifiable, unless all, including physicians, are willing to forego constitutional guarantees. While physicians can take measures to protect themselves, such as home and office security measures, security-conscious travel, restricting access to the home address, and the use of self-defense weapons,[12] these precautions may appear overly draconian.

While physicians infrequently become erotomanic objects of their patients, the problem should not be underappreciated. It is an important warning signal for definitive action. Physicians also need to be aware of the related nondelusional erotomania or obsessive love that can be as troublesome as the delusional erotomania shown by the case reported here.[11,13,14] While treatment of the underlying mental disorder may not always be successful, early recognition and psychiatric and legal interventions may forestall tragedy. This case illustrates the infrequent but highly troublesome conundrum faced by the physician who is a patient's erotomanic object.

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